STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155666	A. BUILDING _____ B. WING _____	R-C 08/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEY HEALTHCARE	**1751 WESLEY ROAD AUBURN, IN 46706**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00113716 and Complaint IN00113278 completed on August 10, 2012. This visit was in conjunction with a PSR to the Recertification and State Licensure Survey completed on May 29, 2012. This visit was in conjunction with a PSR to the Investigation of Complaint IN00109705 completed on July 6, 2012. Survey dates: August 21, 22, & 23, 2012 Facility number: 000307 Provider number: 155666 AIM number: 100285660 Survey team: Sue Brooker RD TC Rick Blain RN Census bed type: SNF/NF: 58 Total: 58 Census payor type: Medicare: 11 Medicaid: 39 Other: 8 Total: 58 Sample: 3 Wesley Healthcare was found to be in compliance with 42 CFR Part 483, Subpart B and	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155666	A. BUILDING _____ B. WING _____	R-C 08/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 000}	Continued From page 1 410 IAC 16.2 in regard to the PSR to the Investigation of Complaint IN00113716 and Complaint IN00113278. Quality review 8/24/12 by Suzanne Williams, RN	{F 000}		